immortality" as important factors for the mushrooming number of malpractice suits.

In my opinion medical doctors and hospitals have been an object of discrimination of scandalous proportions.

The reasons are:

1. Availability of huge amounts of money from insurance carriers whose losses are covered by ever-increasing premiums.

2. The openhanded leniency of the courts to accept settlements for disproportionate and enormous amounts of money for claims against doctors and hospitals without consideration as to the impact of such settlements on society to a point where administration of justice is rapidly becoming a form of extortion.

3. The financial gains in store for successful trial lawyers—whose earnings from a single settlement have amounted up to 50 percent of sums awarded to the plaintiff.

What is a reasonable fee for a lawyer? Should the consumer have a say? Should there be upper limits for liabilities incurred during the delivery of medical care? Should spiraling insurance premiums go unchecked by the many who have to pay for the gains of the few? Why should doctors or anybody be subject to indignities while in court, and the most common principles of decency be ignored in order to impress the jury? Why should a medical doctor be discriminated against, be treated more harshly, and pay settlements, than those who commit premeditated capital crimes, political crimes, or those who are responsible for industrial or military negligence that has all too frequently cost millions of dollars and scores of lives?

If accountability is at stake, why should those courts who are responsible for the freedom of criminals known to be repeaters of serious crimes, or prison officials under whose management prisoners escape or suffer bodily harm by the hands of other jailmates, go unpunished?

Are the best interests of the public met by closing our eyes to these realities? I suggest:

1. A limitation by law on maximum allowance for settlements that does not discriminate against providers of medical care.

2. A professional conduct and peer review committee that includes consumer interests with enforcing power should be established for the lawyers, with power to establish equitable ranges of earnings.

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Traumatic Injury —A Health Care Crisis

TO THE EDITOR: I wish to compliment you for printing the article by Trunkey, Lim, and Blaisdell [Trunkey DD, Lim RC Jr, Blaisdell FW: Traumatic injury—A health care crisis. West J Med 120:92-94, Jan 1974] on the neglected health care crisis of trauma. Their delineation of the problem was dramatic, accurate, and timely. Inevitably, however, outlining the solution is far more difficult.

As the authors pointed out, there are 42, or perhaps more separate agencies trying to deal with separate aspects of this problem. Despite their efforts, the epidemic of accidental death and injury has gained in magnitude and seriousness.

If we are to learn the lessons of history, we would do well to look at the experience of agencies concerned with cardiovascular disease and cancer. In both of these cases, really effective, broadly-based action was delayed pending the launching of an educated campaign by an aroused public. The American Heart Association and the American Cancer Society were both extremely influential in the arousal and education of the public. At present, these two societies alone have a combined budget of close to one hundred fifty million dollars per year and can put an army of many thousands of volunteers into the field. Because of the massive public support and through the influence of a few powerful political, business, and professional figures, the millions of dollars of support donated by the citizens of this country have been expanded by federal and foundation support to attack the problems of cancer and vascular disease through research, education of the public, and key service efforts. If a physician wishes to obtain transportation for a cancer victim, for instance, he can, in almost any major city in the country, merely call the Cancer Society and the transportation will be provided. Obviously, there is no counterpart for trauma, despite the fact that it is the third major killer and probably the major disabler of young, productive people in this country.

Because of this lack, the National Research Council, in 1966, recommended the formation of an American Trauma Society to offer a "global" interest in the problems of trauma and to organize and arouse public response through the three basic avenues of service, education, and research. The American Trauma Society, with national head-

quarters in Hershey, Pennsylvania, is now three years old, and, with the generous support of the American Cancer Society and the American Heart Association, has over 1,500 founding members across the country, and now has nine organized state divisions, including California, with many other states in the process of forming divisions. There are over 120 founding members in California, and we would like to increase this number manyfold. Anyone interested in further information may contact the undersigned.

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Rigid Tube Bronchoscopy

TO THE EDITOR: In your November 1973 issue there is a summary on fiberoptic bronchoscopy by Lowell E. Renz. [Renz LE: Fiberoptic bronchoscopy, *In* Important advances in clinical medicine —Chest diseases. Calif Med 119:42-43, Nov 1973] I agree with Dr. Renz that the development of flexible fiberoscopy is an important one and there is no question that the art and science of flexible fiberscopes of all types will increase over the years.

However, I object completely to his observation that the hazards and risks of performing a rigid tube bronchoscopy frequently outweigh the benefits when applied in respiratory failure. This is simply not so and I think it is a disservice to suggest to younger physicians and surgeons that rigid tube bronchoscopy is outmoded. I have been using the rigid tube for nearly forty years and I have bronchoscoped innumerable people with respiratory failure and with postoperative atelectasis without any complications insofar as use of the rigid tube is concerned. Continuous ventilation is, of course, possible with the rigid tube. By and large, therapeutic bronchoscopy and particularly aspiration is much better accomplished by the rigid tube than it is by the flexible fiberscope. It has been standard procedure for years to use a rigid tube in a patient's room, or in intensive care and I have never seen any ill effects from it. I think it is high time that we recognize the advantages and the benefits of the flexible fiberoptic bronchoscope, realizing at the same time that these benefits should be placed in proper prospective to the uses of the rigid tube.

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The Author Replies

My article did not state that rigid bronchoscopy has been outmoded. It was not intended to be an in-depth discussion of the pros and cons of rigid versus flexible fiberoptic bronchoscopy. It was intended to be a brief description of the instrument and short résumé of the uses of the flexible fiberoptic bronchoscope.

The term *respiratory failure* was intended to identify those patients with decompensated chronic obstructive pulmonary disease. Many of these patients require intubation and ventilatory assistance. Removal of the endotracheal tube and immediate insertion of rigid bronchoscope requires general anesthesia and/or muscle relaxants. General anesthesia in the hypoxic or acidotic patient represents increased liability for cardiovascular complications. Although ventilating rigid bronchoscopes have been available for many years, it was recently pointed out that certain techniques and types of ventilating bronchoscopes were insufficient in maintaining alveolar ventilation.[1] This was reflected in progressive respiratory acidosis. The bronchofiberscope does not require general anesthesia or paralyzing muscle agents since it can be utilized through an endotracheal tube while maintaining adequate, uninterrupted ventilatory assistance.

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REFERENCE

1. Morales G, Epstein B, Cinco B, et al: Ventilation during general anesthesia for bronchoscopy. J Thorac Cardiovasc Surg 57:873, Jun 1969